STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155252	A. BUILDING 00 B. WING	12/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-WOODLANDS	4088 FRAME RD NEWBURGH, IN47630

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 28-30, December 1, 2, 6, 7, 2011 Facility number-000155 Provider number-155252 AIM number-100266830 Survey team: Diane Hancock, RN, TC Vickie Ellis, RN Amy Wininger, RN 11/28, 11/29, 11/30, 12/1, 12/6, 12/7/11 Barbara Fowler, RN 11/29, 11/30, 12/1, 12/2, 12/6, 12/7/11 Census bed type: SNF/NF: 106 Total: 106 Census payor type: Medicare: 9 Medicaid: 74 Other: 23 Total: 106 Sample: 22 Supplemental sample: 17 These deficiencies also reflect state	F0000	*Preparation and submission of this Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed 12/14/11 Cathy Emswiller RN			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. During observation, record review and interview, the facility failed to ensure services were provided in accordance with the written plan of care, for 2 of 2 supplemental sample residents reviewed for blood glucose checks, in the supplemental sample of 17, and for 4 of 22 sampled residents reviewed, in that blood glucose were checked while residents were eating, blood pressure and pulse was not checked prior to medication administration, medications were not provided in accordance with physician's orders, a resident was not turned and repositioned as ordered and/or care planned, and barrier creams were not applied as care planned. (Residents #78,	F0282	**--F282 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** LPN #1 was immediately inserviced on monitoring of blood glucose prior to meals. RN #1 was immediately inserviced on checking BP and Pulse following parameters prior to administering Diltiazem. Resident #89 Caltrate order was clarified with the physician for Caltrate 600 with vit. D 400. ; CNA #1& 2 were immediately inserviced on providing skin protection ointment after incontinence care.; CNA's caring for resident #36 were immediately inserviced on turning and repositioning and floating heels along with LPN #3. **--How other residents have the potential to be affected will be**	01/06/2012

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	#106, #88, #89, #31, #36) Findings include: 1. During observation of the medication pass on 11/29/11 at 11:57 AM, Resident #78 had her accucheck [blood glucose] obtained by LPN #1 while she was eating lunch in her room. During observation of the medication pass on 11/30/11 at 11:55 AM, Resident #78 was observed to be eating lunch in the activity room. Resident #78 was taken to her room during her meal and LPN #1 obtained accucheck from Resident #78. The clinical record for Resident #78 was reviewed on 11/29/11 at 12:30 p.m. Physician's orders dated 11/23/11 indicated accuchecks were to be obtained before meals for sliding scale coverage. 2. During observation of the medication pass on 11/29/11 at 12:20 PM, Resident #106 had his accucheck obtained by LPN #1 while he was eating lunch. During observation of the medication pass on 11/30/11 at 12:05 PM, Resident #106 was observed to be eating lunch in the lobby. Resident #106 was taken to his room and the accucheck was obtained by LPN #1 for sliding scale insulin coverage.		**identified** All residents requiring BS monitoring were identified and will have their blood glucose checked prior to meals. All residents receiving Diltiazem were identified and will have BP & P taken prior to administration of the medication. All Caltrate with Vit D orders were reviewed for accuracy. All residents requiring peri care were identified and will have barrier cream applied after peri care. All residents requiring a T&R program and heels floated according to the care plan have been identified and will have their care plan followed. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Licensed nurses were inserviced 12/28/11 re: Blood Glucose monitoring must be done before meals, BP and Pulse must be taken prior to administering Diltiazem and Parameters followed. Medications delivered from pharmacy will be compared to the MD order for accuracy. CNAs were inserviced 12/29/11 on applying barrier cream after peri care and floating heels on residents with or without air mattresses and on the Turn and Reposition programs. **--How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** DNS /Designee will	

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	Resident #106's clinical record was reviewed on 11/29/11 at 12:30 p.m. and physician's orders dated 10/12/11 indicated the accuchecks were to be done before meals for sliding scale coverage. 3. During observation of the medication pass on 12/1/11 at 11:55 PM, RN #1 was observed administering Diltiazem to Resident #88. During observation of medication pass, Resident #88 had no blood pressure or pulse obtained prior to administration of Diltiazem. During an interview on 12/1/11 at 11:55 AM, RN #1 was queried regarding obtaining blood pressure and pulses prior to giving Diltiazem. RN #1 stated that " blood pressures and pulses are taken early in the morning on all residents." The clinical record, reviewed on 12/1/11 at 12:45 P.M., indicated that Resident #88 was to have his blood pressure and pulse obtained prior to taking Diltiazem and order to not give if systolic blood pressure was less than 90 or pulse was less than 60 and to notify physician. 4. During observation of the medication		monitor 2x per week x 4 weeks, weekly x4 weeks then monthly ongoing and will report findings and trends to QAA for 6 months unless further monitoring is deemed necessary at that time. The data will be analyzed for patterns and trends and action plans written and implemented as needed. **--Systemic changes will be completed by January 6 th , 2012.**	

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	pass on 12/1/11 at 9:10 AM, Resident #89's MAR [Medication Administration Record] read Caltrate 600 with Vitamin D 200 mg [milligram] tablet 1 by mouth twice a day. Resident #89 had Caltrate 600 with Vitamin D 400 mg in the medication drawer which were sent from Resident #89's pharmacy. There were 2 different packages in which a total of 60 tablets of Caltrate 600 with Vitamin D 400 mg had been sent to the facility for Resident #89 from the pharmacy. The 2 packages had a total of 24 tablets out of 60 tablets remaining. RN #1 did not administer the medication as wrong dose had been sent from the pharmacy. During review of Resident #89's record, on 12/1/11 at 10:15 A.M., the order was for Caltrate 600 with Vitamin D 200 mg, ordered on 7/19/11. 5. The clinical record of Resident #31 was reviewed on 11/30/11 at 11:30 A.M. The clinical record indicated the diagnoses included, but were not limited to, dementia and urinary incontinence. On 11/30/11 at 10:30 A.M., CNA [Certified Nursing Assistant] #1 was observed to provide incontinence care to Resident #31. CNA #1 was not observed at any time to apply skin protectant			

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	ointment to Resident #31. On 12/02/11 at 10:40 A.M., CNA #2 was observed to be performing incontinence care for Resident #31. CNA #2 was not observed at any time to apply skin protectant ointment to Resident #31. During an interview with LPN #2, on 11/30/11 at 2:15 P.M., she indicated, "[Resident #31] should have barrier cream applied after each incontinence episode." The CNA Assignments sheets provided by the DoN [Director of Nursing] on 12/01/11 at 10:15 A.M., indicated Resident #31 was to have skin barrier applied. A Care Plan for Pressure ulcer at risk, dated 11/16/11, included, but were not limited to, the following interventions, "...and apply barrier cream..." 6. The clinical record for Resident #36 was reviewed on 11/28/11 at 03:00 P.M. and indicated a diagnosis of diabetes and left sided weakness. The Clinical Health Assessment dated 9/20/11 indicated the resident was at risk for pressure ulcers with a Braden Scale [an assessment tool used to determine pressure risk] score of 15. The Nursing Notes on 9/2/11 at 11:39 P.M. indicated a pink area to the right			

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	buttocks. Wound measurements dated 9/26/11 indicated the area was a stage II area 1 centimeter long by 1.3 centimeters wide by less than 0.1 centimeters deep. An observation, on 11/28/11 at 3:10 P.M., was made of Resident #36 being turned from back to right side. A Duoderm [type of wound dressing] to Resident #36's right buttocks area was also observed and heels were laying directly on the bed. An observation, on 11/29/11 at 09:05 A.M., was made of Resident #36 lying in bed on right side and heels were in contact with the bed. An observation, on 11/29/11 at 10:15 A.M., was made of Resident #36 lying in bed on right side and heels were in contact with the bed. An observation, on 11/29/11 at 11:15 A.M., was made of Resident #36. The resident continued to lay on right side and heels in contact with bed. An observation was made on 11/29/11 at 2:00 P.M., of Resident #36 lying in bed on left side with heels in contact with bed. An observation was made, on 11/29/11 3:15 P.M., of Resident #36 lying in bed on left side with heels in contact with bed.			

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	The record review, on 11/28/11 at 03:00 P.M., indicated a care plan for Resident #36 with an intervention to float heels, initiated on 1/28/11. The care plan also indicated Resident #36 had an intervention implemented on 11/17/2011 for turning and repositioning schedule per assessment. During an interview conducted on 11/30/11 at 09:05 A.M. with Licensed Practical Nurse [LPN] #3, the LPN indicated Resident #36 did not need heels floated because she had a pressure reducing mattress. An observation on 12/1/11 at 3:00 P.M. indicated the mattress was a pressure reducing air mattress but not an alternating air flow mattress to relieve pressure off of heels. In an interview with the DoN on 11/30/11 at 4:00 P.M. the DoN indicated she reviewed Resident #36's case and determined Resident #36 had acquired the pressure ulcer on the buttocks at this facility. 3.1-35(g)(2)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure 1 of 7 residents reviewed for pain management, in the sample of 22, received treatment for the pain during 1 of 7 days of the survey, in that the prescription ran out. (Resident #117) Finding includes: Resident #117's clinical record was reviewed on 11/30/11 at 11:40 a.m. The resident's Diagnoses included, but were not limited to, diabetes, pulmonary disease, and artropathy. The resident's initial Minimum Data Set [MDS] assessment, dated 4/22/11, indicated the resident had frequent moderate pain. The Quarterly assessment dated 10/21/11 indicated the same. The resident's	F0309	**--F309 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Lortab was reordered by the physician for resident #117 on 12/1/2011 and received from pharmacy 12/1/2011. **--How other residents have the potential to be affected will be identified** All residents receiving PRN narcotics and were identified and their supply of medications were reviewed as necessary **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Charge nurse will be responsible for reodering routine and PRN	01/06/2012

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	physician's orders, signed 10/18/11, indicated an order for Lortab [narcotic pain medication] 7.5-500 milligrams [mg] one tab by mouth every 4 hours as needed for pain. Resident #117 indicated, on 12/1/11 at 9:05 a.m., there was a problem getting her pain medication renewed. She indicated she was hurting, with pain in her shoulder and knee. She indicated there had been problems before and she had waited a whole day to get pain medication. LPN #1 was interviewed, at 9:10 a.m. on 12/1/11. He indicated she had asked for Lortab during the night and the pharmacy needed a script for renewal. The resident's physician had been notified early that morning, but he indicated he wouldn't do anything until his office hours. RN #2, the Unit Manager, indicated the pharmacy was supposed to notify the physician 2 weeks before the prescription expired and the physicians didn't always respond. "We don't know until it runs out." There was no indication the facility staff observed for low numbers of medications and attempted to call the physician before it was completely out. RN #2 indicated the pharmacy would not allow them to take controlled drugs out of		medication 3 days before medication supply runs out. All Licensed Nurses were inserviced on 12/28/2011 regarding reordering of medications timely. **--How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** PRN narcotics reorders will be monitored for 4 weeks and then monthly ongoing by the DNS or designee. Findings and trends will be reported to QAA x 6 months unless further monitoring is deemed necessary at that time. --Systemic changes will be completed by January 6 th , 2012.	

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	the Emergency Drug Kit without a current unexpired order. On 12/1/11 at 4:30 p.m., Resident #117's pain medication was still unavailable. The Medication Administration Record indicated she received Tylenol at 10:15 a.m. on 12/1/11 for a pain level of 7, with relief documented as a level 5. The resident received Lortab on 12/2/11 at 0145 [1:45 a.m.]. Her pain level was assessed at a 7, with relief documented at a 4 at 3:00 a.m. 3.1-37(a)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure 1 of 2 sampled residents reviewed for pressure sores, in the sample of 22, received treatment and services to prevent further sores from developing, in that the resident was not always turned timely and	F0314	**F314 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice.** CNA's for resident #36 were immediately inserviced on turning and repositioningevery two hours and floating heels for resident #36. LPN #3 was	01/06/2012

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	failed to have heels floated in accordance with the care plan. (Resident #36) Finding includes: The clinical record for Resident #36 was reviewed on 11/28/11 at 03:00 P.M. and indicated a diagnosis of diabetes and left sided weakness. The Clinical Health Assessment dated 9/20/11 indicated the resident was at risk for pressure ulcers with a Braden Scale [an assessment tool used to determine pressure risk] score of 15. The Nursing Notes on 9/2/11 at 11:39 P.M. indicated a pink area to the right buttocks. Wound measurements dated 9/26/11 indicated the area was a stage II area 1 centimeter long by 1.3 centimeters wide by less than 0.1 centimeters deep. An observation, on 11/28/11 at 3:10 P.M., was made of Resident #36 being turned from back to right side. A Duoderm [type of wound dressing] to Resident #36's right buttocks area was also observed and heels were laying directly on the bed. An observation, on 11/29/11 at 09:05 A.M., was made of Resident #36 lying in bed on right side and heels were in contact with the bed. An observation, on 11/29/11 at 10:15 A.M., was made of Resident #36 lying in		immediatelyinserviced on floating heels even with an air mattress. Resident #36 will be turned and repositioned every two hours with heels floated as care planned. **How other residents have the potential to be affected will be identified.** All residents requiring turning and repositioning and heels floated have beenidentified and care plans updated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Licensed Nurses inserviced 12/28/2011 and CNAs inserviced 12/29/2011 regarding turning and repositioning, floating heels, and residents with air mattresses requiring heels to be floated.Also, pillows will be used for heel floating. **How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** Director of Nursing/Designee will monitor two times a week, every week for four weeks. Then monthly on going. Findings will be reported monthly in QAA x 6 months unless further monitoring is deemed necessary at that time. The completion date will be January 6, 2012.	

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	bed on right side and heels were in contact with the bed. An observation, on 11/29/11 at 11:15 A.M., was made of Resident #36. The resident continued to lay on right side and heels in contact with bed. An observation was made on 11/29/11 at 2:00 P.M., of Resident #36 lying in bed on left side with heels in contact with bed. An observation was made, on 11/29/11 3:15 P.M., of Resident #36 lying in bed on left side with heels in contact with bed. The record review, on 11/28/11 at 03:00 P.M., indicated a care plan for Resident #36 with an intervention to float heels, initiated on 1/28/11. The care plan also indicated Resident #36 had an intervention implemented on 11/17/2011 for turning and repositioning schedule per assessment. During an interview conducted on 11/30/11 at 09:05 A.M. with Licensed Practical Nurse [LPN] #3, the LPN indicated Resident #36 did not need heels floated because she had a pressure reducing mattress. An observation on 12/1/11 at 3:00 P.M. indicated the mattress was a pressure			

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	reducing air mattress but not an alternating air flow mattress to relieve pressure off of heels. In an interview with the DoN on 11/30/11 at 4:00 P.M. the DoN indicated she reviewed Resident #36's case and determined Resident #36 had acquired the pressure ulcer on the buttocks at this facility. On 12/6/11 at 3:00 P.M., the Administrator provided the Clinical Guideline: Skin Integrity document, dated 2/25/10. The document indicated a positioning schedule to meet individual resident needs and minimize concentrated pressure to skin would be utilized. The document also indicated positioning devices such as pillows or foam wedges were recommended to keep bony prominence's from direct contact with one another. 3.1-40(a)(1) 3.1-40(a)(2)			

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F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. During observation, record review, and interview, the facility failed to ensure 1 of 1 resident with a discontinued catheter, in the sample of 22, was provided services to evaluate urinary output and bladder status following the discontinuation of the catheter. (Resident #99) Finding includes: The clinical record of Resident #99 was reviewed on 11/29/2011 at 8:50 AM. The clinical record indicated the resident was admitted on 11/22/11 and the diagnoses included, but were not limited to, S/P [status post] closed fracture left intertrochanteric femur and right bundle branch block. The clinical record indicated, on 11/28/2011, Resident #99 had a physician's order to discontinue his foley catheter and to straight catheterize the	F0315	**--F315 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Resident #99 was placed on Intake and Output x 72 hours. A 3 day voiding assessment was performed. A bladder assessment was completed. **--How other residents have the potential to be affected will be identified** All residents requiring foley catheters to be discontinued will be place on Intake and Output x 72 hours, a 3 day voiding assessment performed, and a bladder assessment will be completed. No other residents were affected. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Licensed Nurses were inserviced on 12/28 upon D/C of a foley catheter the resident is to be placed on Intake and Output x 72 hours, a 3 day voiding assessment will be performed and a new bladder assessment	01/06/2012

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	resident every shift PRN [as needed] for 48 hours for inability to void and document volumes. Resident #99's foley catheter was discontinued on 11/28/11 at 11:30 PM. The policy for discontinuing foley catheters, dated as revised January 2011, was received from the Director of Nurses on 12/2/11 at 12:30 P.M. The Post-catheter Removal Interventions policy indicated that the resident is to have urinary output and bladder status monitored for 72 hours to observe for: decreased urinary output, bladder distention, and presence of pain or discomfort upon bladder palpation. Upon review of the clinical record, there was no assessment to determine if the resident was experiencing problems with urinary output, bladder distention, or presence of pain or discomfort upon palpation. When RN #2 was queried regarding urinary output on 11/29/11 at 9:30 A.M., RN #2 indicated that urinary outputs are documented on residents with foley catheters. RN #2 was unable to find any documentation for post-foley output for Resident #99.		will be completed. CNAs were inserviced on 12/29 on the need for a 3 day Intake and Output after a foley catheter is discontinued. **--How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** Director of Nursing/designee will be responsible for monitoring each time a foley catheter is discontinued which will be ongoing. Findings and trends will be reported in QAA x 6 months unless further monitoring in QA is deemed necessary at that time. **--Systemic changes will be completed by January 6th 2012.**	

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	Upon interview of RN #1 on 11/29/11 at 11:15 A.M., she indicated that intakes and outputs were not normally obtained on residents; that residents with urinary problems had their bladders palpated; and the facility would benefit from a bladder scanner. 3.1-41(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure interventions to prevent falls were always in place and functioning, for 1 of 8 sampled residents reviewed for falls, in the total sample of 22, in that interventions were removed for unknown reasons or interventions did not function as designed and the resident continued to fall. (Resident #23) Findings include:	F0323	**--F323 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Resident #23 was reassessed and care plan updated with new preventative fall measures **--How other residents have the potential to be affected will be identified** Repeated falls have been identified and care plans updated. Residents with alarms have been	01/06/2012

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	The clinical record for Resident #23 was reviewed on 11/29/11 at 9:45 A.M. The record review indicated Resident #23 had a diagnosis of right sided weakness and dementia. The Nursing Notes for Resident #23 indicated Resident #23 fell on the following dates and times: 7/7/11 at 4:51 A.M., Resident #23 fell in "nursing room," and hit right eye. 7/17/11 at 6:52 A.M., staff observed Resident #23 had an abrasion to left eye above brow measuring 1.5 cm [centimeter] x 3 cm. 8/3/11 at 1:10 P.M., Roommate stated, Resident #23 "just laid down on the floor beside her bed." 8/5/11 at 9:15 A.M., Resident #23 " found on floor beside her bed face down at 9:30 in pool of blood". 8/25/11 at 4:10 A.M., Resident #23 "found on the floor, in front of her bed". 8/29/11 at 9:38 A.M. indicated the intervention of soft mat was discontinued per Resident's doctor, because of risk to Resident #23. 8/29/11 at 1:57 P.M., Nurse called by roommate. Resident #23 "lying on right side just inside door with head pointed toward hallway door". 9/1/11 at 4:44 A.M., Resident #23 "found laying on floor next to bed, face down".		identified and reassessed and their care plans updated. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Licensed Nurses and Certified Nursing Assistants were inserviced on 12/28/2011 and 12/29/2011 on answering alarms timely and implementing preventative fall measures immediately. All falls and preventative measures will be reviewed in clinical start up meetings daily to ensure changes are in place and effective. **--How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** Director of Nursing/Designee will monitor alarm use 2 times a week for 4 weeks, weekly for four weeks, and then monthly ongoing. Findings and trends will be reported monthly x 6 months to QAA unless further monitoring is deemed necessary at that time. --Systemic changes will be completed by January 6 th , 2012.	

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	10/3/11 at 3:23 P.M., indicated the seat belt restraint was removed from the wheelchair on 10/3/11 at 3:23 P.M. 10/3/11 at 10:13 P.M., Resident #23 "sitting on buttocks in front of the nurses' station". 10/25/11 at 2:00 A.M. for Resident #23 indicated Resident #23's alarm was sounding, and staff found Resident #23 "on the floor face down and bleeding", which resulted in injury to the patient and patient being sent to the hospital. 11/8/11 at 1:00 A.M., Resident #23 fell "found lying on the bathroom floor was carrying clip alarm, alarm on bed not sounding." The care plan for Resident #23 for being at risk for falls, initiated on 5/13/2011, included, but was not limited to, the following interventions: Activity Programming Assess for pain Bed in low position Footwear to prevent slipping Environment well lit and free of clutter Observe for side effects of medication Therapy referral 7/7/11 Resident to wear velcro instead of shoes with laces 7/17/11 Removed over bed tables from room 7/17/11 Room reassessed for safety to			

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	provide more room to enter and exit bed on right side, and furniture moved away from head of bed. 8/3/11 Nonslip strips placed on the floor on open side of bed 8/5/11 Alarm mat on open side of bed (discontinued due to resident perception of it being a black hole and attempting to step over it) 8/8/11 Perimeter scoop mattress on bed 8/25/11 Soft mat applied to open side of bed (discontinued on 8/29/11 at 9:38 A.M. due to resident picking it up and putting it in bed with her) 8/29/11 Discontinued Ted hose, started orthostatic blood pressures 9/1/11 Low bed, soft mats, and room change 10/4/11 Replaced self releasing alarm belt 10/25/11 Physical Therapy and Occupational Therapy Evaluation 11/8/11 Pressure alarm mattress to bed and alarming mat at bedside In an interview on 11/30/11 at 3:05 P.M. with the Director of Nursing [DoN] and Administrator, the DoN indicated the soft mat was removed on 8/29/11 in the A.M. and the patient fell on 8/29/11 that afternoon. The DoN indicated no intervention had been put into place at the time of the fall. They were unable to provide an explanation as to why the seat belt had been removed on 10/3/11 prior to			

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	the resident's fall. The intervention added, on 10/4/11, was just to replace the self-release alarm belt. Regarding the 11/8/11 fall, they reiterated the alarm was not sounding, but did sound when they put the resident back to bed. Their additional intervention was for a pressure alarm to the bed, which had already been in place, but had not alarmed. The alarming mat had already been attempted previously. On 12/1/11 at 4:56 P.M., Resident #23 was observed in an occupied resident room on Arbor Unit (not her unit). Her shirt was off, her alarming seat belt was off and the alarm was sounding. She was removing pillows from bed B in the room. At 4:58 P.M., two unidentified staff members walked past the room. At 5:00 P.M., LPN #4 entered the room. The alarm was continuing to sound. She indicated she had heard the alarm from the Rosegate Unit, near the nurses' desk. She proceeded to assist the resident to put her shirt on and took her to her room to lie down. On 12/6/11 at 3:00 the Administrator provided Fall Management and Clinical guidelines document, dated 1/2011, the document indicated "appropriate interventions are implemented following a residents fall", and "new interventions			

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	will be identified and immediately implemented to reduce the potential for falls to reoccur". 3.1-45(a)(2)			
F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 5 medication errors out of 47 opportunities for error, resulting in an 10.6% error rate. This affected 3 of 19 residents observed for medication pass (Residents #78, #106, #88), and 2 of 4 nurses observed to pass medications. (LPN #1, RN #1) Findings include:	F0332	**--F332 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** LPN #1 was immediately inserviced on obtaining blood glucose before meals. Order for Robitussin for Resident #88 was clarified per MD and may be administered PO or per tube. **--How other residents have the potential to be affected will be identified** All residents requiring blood glucose monitoring were	01/06/2012

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	1. During observation of medication pass on 11/29/11 at 12:05 PM, LPN #1 was observed to obtain a blood glucose from Resident #78 with the result of 137. He proceeded to administer Novolog Insulin 4 Units subcutaneously at that time, based on the blood glucose. Resident # 78 was observed to be eating lunch when the blood glucose was obtained. During observation of medication pass on 11/30/11 at 11:55 AM, LPN #1 was observed to obtain a blood glucose from Resident #78 of 200. LPN #1 administered 8 units of Novolog Insulin based on the blood glucose. The resident was observed to be eating lunch during the blood sugar check. During record review of Resident #78 on 11/29/11 at 12:40 PM, the record indicated the blood glucose was to be obtained before meals. 2. During observation of medication pass on 11/29/11 at 12:20 PM, LPN #1 was observed to obtain accucheck from Resident #106 with the result of 294. He proceeded to administer Novolog Insulin 8 Units subcutaneously at that time, based on the blood glucose. The resident was observed to be eating lunch when the		identified and will have their glucose checks done before meals. All residents with G Tube medication route of administration were identified , reviewed and clarified as needed. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Licensed Nurses were inserviced 12/28 on observing for correct route of med administration for Gtube residents. DNS/Designee will assess Gtube medications on admit and monthly. **--How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** DNS/Designee to monitor medication route on G Tube patients on admission and then monthly. Findings and trends will be monitored in QAA x 6 months unless further monitoring is deemed necessary at that time.. **--Systemic changes will be completed by January 6 th , 2012.**	

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	blood glucose was obtained. During observation of medication pass on 11/30/11 at 12:05 PM, LPN #1 was observed to obtain accucheck from Resident #106 of 277. LPN #1 administered 8 units Novolog Insulin based on the blood glucose. The resident was observed to be eating lunch during the blood glucose check. During record review of Resident #106, on 11/29/11 at 12:40 PM, the record indicated the blood glucose was to be obtained before meals. 3. During observation of medication pass on 12/1/11 at 11:55 AM, RN #1 was observed administering Robitussin 10 ml [milliliters] through gastrojejunostomy tube of Resident #88. During record review of Resident #88 on 12/1/11 at 12:45 PM, the record indicated that on 8/30/11 the order was received for Robitussin 10 ml was to be administered by mouth. 3.1-25(b)(9)			

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F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure menus were followed, for 4 of 22 sampled residents (#119, #120, #121, #89), and 3 of 3 supplemental sample residents, in the supplemental sample of (#79, #65, #22), in that residents had selective menus and selected items were not served. Findings include: 1. Resident #119, in a confidential interview on 11/29/11 at 8:45 a.m., indicated she filled out menus but didn't get what she ordered. Resident #120 was confidentially interviewed on 12/1/11 at 6:11 p.m. He indicated he usually didn't get what he ordered. Resident #121 was confidentially interviewed on 12/1/11 at 4:30 p.m. She indicated she did not always get what she selected from the menu. 2. Resident council minutes, reviewed on 12/6/11 at 1:40 p.m., indicated during the	F0363	**F363 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Corrective action was immediately conducted by the DSM by providing education with the cook and aide on duty on following menus, including selective menus, spreadsheets & recipes. Resident #45 was provided an option for dessert from the MDR dessert cart which included a variety of desserts including butterscotch pudding. Resident #45 selected chocolate pudding as preference. **--How other residents have the potential to be affected will be identified** In-service was given to all cooks and diet aides on following menus and spreadsheets as written, selective menus, and the Living Centers Policy on preparation responsibilities. **Completed 12/30/11. --What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Items	01/06/2012

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	meeting on 10/3/11 at 2:30 p.m., residents indicated that residents with selective menus were being served foods they did not choose. 3. Observations during the evening meal on 12/1/11 at 6:11 p.m. included, but were not limited to, the following: Resident #89 was observed eating his meal in the dining room. His tray ticket indicated he had selected butterscotch pudding. He was provided chocolate pudding, which was not a choice on the selective menu. 4. Observations during the noon meal on 12/2/11 at 12:15 p.m. included, but were not limited to, the following: Resident #119 was observed eating his lunch in his room. His tray ticket indicated he had selected the rye bread and a salad be included in his lunch. He had received neither of the items. Resident #120's tray card indicated she had ordered garlic bread, none was provided. Resident #79 received a salad with no dressing; dressing had been selected. Resident #65 received a salad with no dressing; dressing had been selected. Resident #22 received a salad with no dressing; dressing had been selected. 3.1-20(i)(4)		selected by residents will be highlighted and tallied for each meal on the production sheet by the ADSM or designee. The Dietary Services Manager will monitor (at least 5 meals per week for 4 weeks) the tray line for menu selection compliance, for following spreadsheets to the written and selective menus. The DSM or designee will check tray tickets daily for completeness. The Registered Dietitian during visits will monitor for menu/spreadsheet compliance. **--How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** The Dietary Services Manager will monitor findings and trends with QAA on a monthly basis x 6 months unless further monitoring is deemed necessary at that time. **-** **-Systemic changes will be completed by January 6th 2012**	

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F0364 SS=E	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to ensure food was served at a temperature the residents liked, for 6 of 14 residents in the group interview, and 1 of 3 additional residents interviewed. (Residents #125, #120, #128, #132, #130, #133, #119) Food was observed to be too cool [warm foods] and too warm [cold foods], during observation of 1 of 3 meals (noon meal 12/2/11) (Residents #81, #115). Findings include: 1. During a confidential interview of Resident #119, on 11/29/11 at 8:45 a.m., the resident indicated the food was often cold. During the group interview, on 11/30/11 at 1:30 p.m., 6 of 14 residents present indicated food was often cold, if they ate in their rooms. (Residents #125, #120, #128, #132, #130, #133) 2. During the lunch meal on 12/2/11, the 400 and 600 hall cart was observed on the hall, with staff passing the trays. Resident #81, who required assistance with eating,	F0364	**F364 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Corrective action was immediately conducted by the DSM by providing education with the cook and aide on duty on food serving temperatures and meal delivery times. **--How other residents have the potential to be affected will be identified** In-service was given to all nursing and dining staff on food temperatures, meal/tray delivery order and timeliness by 12/30/11. Food trays for assisted residents to be separated for delivery from non-assisted residents for delivery purposes. Milk for meal service will be placed in freezer approximately 1 hour prior to meal time to assure proper temperature at delivery. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** DSM/designee to monitor steam table temperatures, delivery times, plate warmer operation (early plug in and maximum heating) and cart	01/06/2012

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	155252	A. BUILDING 00 B. WING	12/07/2011

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	had not been served his tray. Resident #115, who also required assistance to eat, had not been served a tray. The meal service for the halls was observed throughout. At 12:20 p.m., CNA #3 was observed beginning to feed Resident #81. Resident #115's tray was still on the cart to be served. Another tray was ordered for Resident #115. At that time, Resident #115's food on the tray stored in the cart was tested for temperature. The milk temperature was 58 degrees Fahrenheit [F]. The yogurt was 58 degrees F. The pureed spaghetti was 110 degrees F. The pureed meatballs were 104 degrees F. The food tasted lukewarm. CNA #3 was then interviewed at 12:25 p.m. on 12/2/11, as she fed Resident #81. She indicated she had not heated up the resident's food or gotten him cold drinks. She stated, "It was warm when I brought it in." 3.1-21(a)(2)		temperatures on residents eating in their rooms (at least 5 meals per week for 4 weeks). In-service was given by DSM to all cooks and diet aides on taking food temperatures, recording and maintaining steam table temperatures, and ensuring proper plate warmer operation (early plug-in and maximum heating). Completed by: 12/30/11Test tray evaluations will be conducted by DSM/designee at least 5 meals per week for 4 weeks. The Registered Dietitian during visits will monitor test tray evaluations.DSM/designee will discuss food temperatures at Food Council or Resident Council monthly x 6months . **--How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** The Dietary Services Manager will monitor findings and trends with QAA on a monthly basis x 6 months unless further monitoring is deemed necessary at that time. **--Systemic changes will be completed by January 6th 2012.**	

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F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and record review, the facility failed to ensure the pharmacy provided the accurate dose of medication, for 1 of 19 current residents sampled, in the total sample of 22, in that Caltrate 600 with Vitamin D 400 tablets were provided and the order was for Caltrate 600 with Vitamin D 200. (Resident #89) Finding includes During observation of the medication pass on 12/1/11 at 9:10 AM, Resident #89's MAR [Medication Administration Record] read Caltrate 600 with Vitamin D 200 mg [milligram] tablet 1 by mouth twice a day. Resident #89 had Caltrate 600 with Vitamin D 400 mg in the	F0425	**F425 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice.** Resident #89 Caltrate order was clarified immediately with the physician order received for Caltrate 600 with vitamin D 400. **How other residents have the potential to be affected will be identified, and verified that the order matches the medicine available.** All residents receiving Caltrate with vitamin D have been identified andverified that the order matches the medicine available. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.**	01/06/2012

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	medication drawer which were sent from Resident #89's pharmacy. There were 2 different packages in which a total of 60 tablets of Caltrate 600 with Vitamin D 400 mg had been sent to the facility for Resident #89 from the pharmacy. The 2 packages had a total of 24 tablets out of 60 tablets remaining. RN #1 did not administer the medication as wrong dose had been sent from the pharmacy. During review of Resident #89's record, on 12/1/11 at 10:15 A.M., the order was for Caltrate 600 with Vitamin D 200 mg, ordered on 7/19/11. 3.1-25(g)(2)		Licensed Nurses are to be in serviced 12/28/2011 relating to medications received from pharmacy, which will be compared with doctor order for accuracy. **How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** Director of Nursing/Designee will monitor Caltrate orders and medicationsavailable monthly on going. Findings will be reported monthly in QAAx 6 months unless further monitoring deemed necessary. The date of completion will be January 6, 2012.	

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure infection control procedures were followed to prevent potential transmission	F0441	**--F441 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** LPN #1 was immediately inserviced on glove	01/06/2012

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	of infections, during care observations of 2 of 3 supplemental sample residents observed for blood glucose monitoring, in the supplemental sample of 17 (Residents #78, #106), and for 1 of 3 sampled residents observed for peri-care, in the sample of 22 (#31). Findings include: 1. During observation of pass on 11/29/11 at 12:05 PM, Resident #78 had accucheck [assessment machine for blood glucose] obtained by LPN #1. While obtaining the blood sample from Resident #78, LPN #1 was observed to wash his hands but not to wear gloves. During observation of medication pass on 11/30/11 at 11:55 AM, LPN #1 removed glucometer machine from medication cart and obtained blood sample from Resident #78. After obtaining blood sample, LPN #1 placed glucometer machine back into medication cart without sanitizing the glucometer machine. At that time, LPN #1 went to Resident #106 's room and removed the same glucometer machine that had been previously used for Resident #78 from the medication cart. LPN #1 placed test strip into machine to obtain blood sample and prepared to enter the		use when performing glucoscans and disinfecting the glucometer after each use. CNA #1 and #2 were immediately inserviced on glove use during pericare and promptly removing their gloves. **--How other residents have the potential to be affected will be identified** All residents have the potential to be affected by this alleged deficient practice. Inservices held 12/28/11 for Licensed Nurses on glucoscan use and disinfecting glucometer. Inservice held 12/29/2011 for Certified Nursing Assistants regarding prompt removing of gloves after pericare. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Licensed Nurses and Certified Nursing Assistants were inserviced on 12/28/2011 and 12/29/2011 on glove use while performing pericare and gloves should be promptly removed after completing pericare. Licensed Nurses were inserviced on 12/28/2011 on glove use when performing glucoscan and disinfecting the glucometer after each use. **--How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** Director of Nursing/Designee will monitor glove use and	

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	room and was stopped from going into Resident #106 room. Upon query of LPN #1, LPN #1 states that sanitizing the glucometer machine was something new and that he had forgotten. LPN #1 then cleaned the glucometer machine with disinfectant wipe. 2. During observation of medication pass on 11/29/11 at 12:20 PM, Resident #106 had accucheck obtained by LPN #1. While obtaining the blood sample from Resident #106, LPN #1 washed his hands but did not wear gloves. The competency evaluation for facility staff for obtaining a drop of blood for accuchecks [no date] was provided by the Administrator on 12/6/11 at 3:28 P.M. It indicated that after washing hands and informing patient being tested what you are going to do, provide privacy, and put on gloves. The policy for Blood Glucose Monitor Decontamination, dated as revised 3/11, was provided by the Director of Nurses on 11/30/11 at 10:30 A.M., stated that "the blood glucose monitor will be cleaned and disinfected with wipes following use on each resident when monitors are shared by		sanitization/disinfecting of glucometer machines and glove use after pericare 2 times a week for 4 weeks, weekly for four weeks, and them monthly ongoing. Findings and trends will be reported monthly to QAA x 6 months unless further monitoring is deemed necessary at that time. --Systemic changes will be completed by January 6th, 2012	

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	multiple residents... Gloves will be worn." 3. The clinical record of Resident #31 was reviewed on 11/30/11 at 11:30 A.M. The clinical record indicated the diagnoses included, but were not limited to, dementia and urinary incontinence. On 11/30/11 at 10:30 A.M., CNA [Certified Nursing Assistant] #1 was observed to don [put on] gloves and provide pericare to Resident #31. During an interview at that time, CNA #1 indicated Resident #31 was, "incontinent of urine." CNA #1 was observed at that time, to cleanse the periarea, touch the resident's bare left forearm, and touch the faucet handles of the sink. CNA #1 was not observed to doff [take off] the soiled gloves until after touching the faucet handles. On 12/02/11 at 10:40 A.M., Resident #31 was observed to be standing in front of the commode with a walker. At that time, CNA #2 was observed to be wearing gloves and providing pericare to Resident #31. After pericare was completed, CNA #2 was observed to touch the walker, the resident's bare left forearm, the faucet handle, and the bathroom doorknob. CNA #2 was not observed to doff the soiled gloves until after touching the bathroom			

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	doorknob. During an interview with CNA #1, on 11/30/11 at 10:40 A.M., she indicated, "We change gloves before and after care." On 12/7/11 at 3:10 P.M., the Administrator provided the Standard Universal Precautions document, which indicated disposable single-use gloves should be worn for resident care and should be promptly removed after use. 3.1-18(b)(1)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the	F0514	**F514 What corrective actions will be accomplished for those**	01/06/2012

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	facility failed to maintain complete and accurate clinical records, for 3 of 22 sampled residents, in that as needed medications were not documented on the Medication Administration Record, and medications were not initialed when given. (Residents #25, #20, #117) Findings include: 1. The clinical record of Resident #25 was reviewed on 12/01/11 at 10:05 A.M. The record indicated the diagnoses included, but were not limited to, osteoarthritis. The November 2011 Physician Order Recap indicated PRN [as needed] orders included, but were not limited to, Norco [a narcotic pain medication] 7.5/325 mg by mouth every four hours as needed for pain. The Norco Controlled Drug Record indicated Norco had been administered to Resident #31 on 11/09/11 at 1:00 A.M. The November 2011 MAR [Medication Administration Record] lacked any documentation that Resident #25 had received Norco 7.5-325 on 11/09/11. 2. The Clinical Record of Resident #20		**residents found to have been effected by the deficient practice.** Resident #25 and Resident #20 the nurses were immediately inserviced on documentation of PRN narcotic use on the MAR and narcotics record. LPN #l was immediately inserviced on documenting medication on the MAR immediately after giving the medications. **How other residents have the potential to be affected will be identified.** All residents receiving prn narcotics have been identified and ordersreviewed. MARs for LPN #l were reviewed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** In-service for Licensed Nurses 12/28/2011 relating to signing medications outimmediately after giving and documentation of prn narcotics on narcotic record and prn MAR record. **How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** DON/Designee will monitor narcotics record, prn Mar and documentation of routine medications on MAR two times a week for four weeks, then weekly times 4 weeks, and then monthly ongoing. Findings and trends will be reported monthly in QAA x 6	

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	was reviewed on 11/29/11 at 9:15 A.M. The record indicated the diagnoses included, but were not limited to, Alzheimer's Dementia. The November 2011 Physician Order Recap indicated PRN orders included, but were not limited to, Norco 5/325 by mouth every 4 hours as needed of pain and Clonazepam 1 mg by mouth four times a day as needed for anxiety. The Controlled Drug Record indicated Resident #20 received Hydrocodone 5-325 mg on 11/13/11 at 10:30 A.M., 3:00 P.M. and 8:00 P.M.; 11/14/11 at 4:00 P.M.; 11/15/11 at 4:00 P.M.; 11/16/11 at 4:00 P.M.; 11/18/11 at 4:00 P.M. and 9:30 P.M.; 11/19/11 at 5:00 P.M.; 11/21/11 at 4:00 P.M.; 11/24/11 at 7:30 P.M.; 11/25/11 at 11:00 A.M. and 4:00 P.M. 11/26/11 at 11:50 A.M. and 4:30 P.M.; and 11/27/11 at 8:00 P.M. The November 2011 MAR lacked any documentation that Resident #20 received any Lortab at these times. The Controlled Drug Record indicated Resident #20 received Clonazepam 1 mg on 11/13/11 at 4:30 P.M., 10:30 P.M.; on 11/14/11 at 8:00 P.M.; on 11/16/11 at 8:00 P.M.; 11/21/11 at 8:00 P.M. 11/23/11 at 10:00 A.M.; on 11/24/11 at		months unless further monitoring is deemed necessary at that time. Completion date will be January 6, 2012.	

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	7:30 P.M., 11/26/11 at 1:00 P.M. and 8:00 P.M. The November 2011 MAR lacked any documentation that Resident #20 received any Clonazepam at these times. In an interview with LPN #2 on 11/29/11 at 1:15 P.M. LPN #2 indicated, "We should document each time we give a PRN medication." On 12/7/11 at 3:10 P.M., the Administrator provided the Monitoring of Medication Administration Policy and Procedure document dated 09/08, which indicated administration of medications is documented, including the frequency and reason for administration of as needed medications. 3. On 12/1/11 at 9:10 a.m., the 400 and 600 hall medication book was reviewed. None of the 8:00 a.m. medications had been initialed as given, including, but not limited to, a blood glucose result and insulin for Resident #117. LPN #1 was interviewed at that time. He indicated he had not signed off on any medications he had given that morning. When queried about the blood sugar, he indicated he had been told by the night nurse the resident's blood sugar was 110,			

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	so he had given one unit of insulin as coverage. He had not documented it. At 9:20 a.m. on 12/1/11, LPN #1 was observed signing all the Medication Records for medications given earlier that morning. 3.1-50(a)(2)			